CONFIDENTIAL

Study of the Provision for Care of the Chronically Ill in New York City

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MEDICAL SOCIAL SERVICE IN RELATION TO THE CARE OF THE CHRONIC SICK

By

Mary C. Jarrett

Welfare Council of New York City
Research Bureau

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FOREWORD

Origin and Scope of the Study

This study was undertaken to discover the extent to which the medical and social agencies of New York City are making adequate provision for the care of the chronic sick. It deals with chronically ill persons dependent in greater or less degree upon the care provided by welfare agencies.

The inquiry was requested by four Sections of the Welfare Council, each of which represents agencies that provide some type of care for the chronic sick, - the Section on the Care of the Aged, the Family Service Section, the Medical Social Service Section, and the Public Health Nursing Section now combined with the Section on Health Administration and Education. A committee from each Section assisted in preparing plans for the study. A Medical Advisory Committee under the chairmanship of Dr. Ernst P. Boas also gave assistance in planning its scope.

The chronic sick for the purposes of the study were defined, following a definition used by Dr. Boas in studies elsewhere, as "persons who have been or are likely to be incapacitated by disease for a period of at least three months, that is, unable to follow the daily routine of the average normal person, whose incapacity will probably continue for an indefinite period." Within this definition, persons are included who

need medical or nursing care in an institution or in their homes and also those who because of unfavorable economic or family conditions need to have attendant care provided either in their own homes or elsewhere. Pulmonary tuberculosis, mental diseases, blindness, and deafness were excluded, since the extent of illness from these causes has been the subject of other investigations and the problems of care for these conditions are fairly well known.

Methods of the Study

A census was taken of persons incapacitated by chronic illness, as defined above, who were under the care of medical and social agencies during a given week in the spring of 1928. A survey was made, during the same period, of the facilities for the care of the chronic sick in agencies of different types.

In order to obtain an appraisal of the medical facilities of the institutions that furnish care particularly for the chronically ill, it seemed desirable to have inspection visits made by a physician with much experience in the institutional care of patients of this type. Dr. Ernst P. Boas fortunately consented to do this. His observations are incorporated in various sections of the report.

Further medical assistance was obtained from Dr. Nicholas Michelson, an associate of Dr. Boas and a member of the Medical Advisory Committee of the study. He reviewed the schedule of each person in the census and indicated: (1) the relative importance of the diagnoses, in cases

where several diagnoses were given, from the standpoint of disability and need of care for chronic illness; and (2) the type of care needed, in his opinion, in the light of all facts recorded on the schedule. A sample group of 1,200 records were then checked by the late Dr. Charles B. Bacon, who at that time was Superintendent of City Hospital. His opinion was in agreement with Dr. Michelson's in all but a small number of cases.

Records of 20,700 persons were obtained from 218 agencies which fall into 8 main groups. The schedules used in the census contained 48 items of information, which were coded and punched on 80 column cards for mechanical tabulation. The field worker in charge of the study in each group of agencies made a survey of facilities and supervised the taking of census records from the agencies' files by recorders or in some instances by the agency's own staff. Mrs. Louise W. GilFillan was the field worker in charge of collecting data on the facilities of medical social service departments; and the part of the report that deals with these facilities is based upon her reports.

Present Status of the Study

A general summary report of the findings of the whole census, a report on special problems of certain groups of chronic diseases, and reports on the census data and the facilities in six groups of agencies - private hospitals, municipal institutions, nursing services, convalescent homes, family service agencies and cardiac after-care services - have been distributed, as they were completed, to members of the Medical Advisory

Committee and to members of the Welfare Council in the Sections chiefly concerned. Other reports have been prepared dealing with the care of the chronically ill in relation to sheltered work agencies and to visiting doctor services. The report covering the census and survey in private homes for the aged was distributed in pamphlet form and is so far the only section of the report that has been published. The report that follows deals with the relation of medical social service departments of hospitals to chronic illness.

The above sections of the report have been prepared with special reference to the requirements of committees and sections of the Welfare Council for detailed data from the study. In addition, a final report, with the title "An Orderly Advance Toward the Prevention and Care of Chronic Illness", which is a general summary and discussion of the findings of the whole study, has been distributed to members of the Welfare Council in mimeographed form. The complete report will be ready for publication during the winter. The first volume of the published report will contain the final summary and discussion; the description and summary of the data of the whole study; the discussion of the data in regard to certain disease groups; and the findings of the census and survey in municipal institutions. The second volume will contain the findings of the census and survey in each type of voluntary agency included.

CONTENTS

TABLES

I

FUNCTIONS OF MEDICAL SOCIAL WORK IN RELATION TO CHRONIC PATIENTS

A chronic disease, whether it results in prolonged illness and incapacity or merely in a limitation of ordinary activities, necessarily creates social problems. Frequently the family as well as the patient are involved in the necessary readjustments. Questions of financial support, change of occupation, altered living conditions, or provision for the care of children may be as fundamental to a patient's welfare as his medical treatment. His state of mind and attitude toward his illness, upon which his readiness to cooperate to his treatment depends, are affected by his ability to deal with such difficulties. The attitudes of different members of his family toward his illness and its consequences must also be taken into account in making plans for a chronic patient.

The chronic sick demand much more of the time of medical social workers than the acutely ill, not only because a larger proportion require assistance in becoming adjusted to their disabilities but also because chronic conditions are as a rule more difficult to diagnose and often can not be understood without the information in regard to social situations and psychological attitudes that constitutes a social examination. In a hospital with a well developed social service, the greater part of the social workers' time is undoubtedly devoted to the chronic patients. Among

a thousand social service cases analyzed to show the functions of hospital social workers, which were selected to represent the practice of various departments throughout the country, approximately half were cases of chronic disease such as this study deals with and the rest were for the most part other forms of chronic disease not included in this study and obstetrical cases.(1)

There seems to be little general recognition, however, of the fact that medical social service is one of the chief agents of treatment for chronic patients. Writing of the importance of the social service in a hospital for chronic diseases, Dr. Boas says: "Happily the time is past when arguments must be marshaled for the justification of social service departments in general hospitals. They have long been accepted as representing an essential phase of hospital activity. But it still seems necessary to insist on the importance of social work in the care of subjects of chronic diseases, whether within or without an institution. This can be due only to lack of interest and inattention, for it is evident, as has been set forth in previous chapters, that the chronicity of disease brings in its train innumerable social and economic complications."(2) He points out that the "problems that arise are most difficult of solution," and he believes that "the social worker will find that she must do more intensive case work than she would in a general hospital; her cases will be of much longer duration, and she will have to maintain very close contact with many of her families for prolonged periods of time."(3)

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(1) The Functions of Hospital Social Service: A Report of the Committee on Functions. American Association of Hospital Social Workers, Monograph No. 1, June, 1930, p. 60.
(2) Boas, Ernst P., M. D., and Michelson, Nicholas, M. D., The Challenge of Chronic Diseases. The Macmillan Company, New York, 1929, p. 140.
(3) Ibid., pp. 141-2.

There is no statistical basis at present for estimating the proportion of patients with chronic diseases as defined in this study among all the patients in hospitals and clinics who need medical social service. The percentage will naturally vary in hospitals of different types and in clinics for different diseases. It has been found that 20 per cent of the patients discharged from one general hospital have no need of social service. (see page 35). It is assumed, however, that dependent chronic patients in hospitals, the group under discussion in this report, with few if any exceptions have social problems requiring some attention from the social service and that their situation should be reviewed by a social worker in order to discover their social needs.

In the prevention of severe illness and serious disability due to chronic disease, the medical social worker has as important a part as in the care and treatment of incapacitated patients. The preventive aspects of their work were stressed by the medical social workers organized by the Section on Medical Social Service of the Welfare Council in a statement of the problem of the chronic patient as it presents itself to them, in which they urged the need for the present study, as follows: "(1) Chronic patients are frequently readmitted to general hospitals for treatment of recurrent acute phases of the disease. They are commonly referred to the medical social service on each discharge. They are a recurrent problem; for social workers consider from their experience that there is not sufficient visiting nursing service to which to refer these patients for home care and that facilities for institutional care of those who for medical or social reasons can not be cared for at home are not sufficient. (2) Certain chronic patients can be kept in condition adequate to a productive life by regular

clinic supervision and treatment; and for many others, more serious incapacity and institutionalization can be prevented by such care. How can medical social service be adequately staffed so that contact may be made with each patient in order to find those who need social care and so that adequate follow-up may be maintained?"

The indifference often found among physicians in general hospitals toward the treatment of chronic diseases is no doubt largely due to their inability to carry out a successful plan of treatment because of a lack of assistance from the social service in making the necessary economic and social adjustments. The physician may realize that his efforts to cure or improve the chronic patient are likely to be futile without continuous oversight of such factors; but he does not always realize that such service can be obtained nor recognize the hospital's obligation to provide it. Too often, the physicians think of the social service only as a means of removing from the wards chronic patients for whom they feel no further responsibility.

The social service encounters great obstacles in the care of chronic patients due not only to the lack of community resources but also to the inability or unwillingness of patients to carry out a long course of treatment. Part of the skill of the trained medical social worker, however, is the ability to influence patients to take a constructive attitude toward their illness and to help them to find and use their individual resources to the best advantage, and at the same time to make the hospital's experience contribute to the development of new resources in the community.

The data on medical social service obtained for this study include a survey of the facilities of 55 social service departments and an item on

the schedule used in taking the census of the chronic sick in hospitals to indicate whether the social service was in touch with the patient. A census of all patients known to the social service departments of the city was not attempted, for most of the departments keep no classification of problems presented or services rendered, a patient whose ability to pay his hospital bill is investigated being classed with one for whom an elaborate plan of social treatment is carried out; so that the figures obtained by a census would have covered too great a range of services to be significant. Clinic patients, who make up the greater part of the case load of the departments, are not included in the study, as it was not found practicable to take the census in clinics. A study of the functions of medical social service departments in relation to the care of the chronic sick, which must necessarily be based upon individual case studies, was outside the scope of the survey.

However, although the data concerning medical social work obtained in the course of the study are limited, there is a good deal of information available to throw light on the practices and standards in this field in New York City and elsewhere. Since medical social service is one of the most important and least understood factors in a community program for control and care of chronic diseases, it has seemed desirable to gather together in this report some of the available information indicating its functions and development in general and the extent to which it is utilized in New York City.

The treatment of cardiac diseases was one of the first medical fields in which medical social work was recognized as essential; and in

New York there has been a further development of social service for cardiac patients than for any other group of the chronic sick. In the standards for cardiac clinics,(1) it is specified that a social worker must be part of a cardiac unit. The patient with heart disease must follow a prescribed regime and to this end he frequently needs continuous personal instruction and help in effecting changes in his way of living. Nevertheless, the staff of many cardiac clinics in New York is still insufficient for adequate service. The superintendent of a children's hospital speaking of children with cardiac disorders said: "What are the vital problems in children's cardiac clinics? Any doctor will tell you that what he can do for these children in the clinic is little beside what can be done for them in their homes. He will tell you that in the search for a cure for this baffling disease, his hands are tied without the knowledge and patient follow-up of the trained social worker."(2) A general hospital superintendent speaking of the necessity for medical social service said: "No amount of surgical skill or expert judgment can bridge the gap between the patient and his life situation without the aid of the medical social worker. If patients suffering from medical complications, particularly cardiac and diabetic conditions are readmitted again and again to our hospitals - is this not frequently due to improper instructions to the patient and his family at the time of discharge - or a lack of information regarding the home into which

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(1) Standard Requirements for a Cardiac Clinic. Prepared by Committee on Cardiac Clinics of the Heart Committee of the New York Tuberculosis and Health Association, Inc., October, 1931.
(2) Social Service and Preventive Medicine. Discussed by John R. Howard, Jr., and Michael M. Davis. Bulletin of the Welfare Council of New York City, vol. 5, No. 4, April, 1931, p. 5.

he is being sent?"[1]

The treatment of diabetes is particularly a medical social problem. The adult patient who must change his mode of life and follow a strict dietary regime needs personal education and encouragement and frequently also assistance in making the necessary changes in his mode of living. For the child with diabetes, the stamina required to follow his regime is as important as medical treatment. As medical social service is most needed at the beginning of treatment, when the patient first learns about his condition, a diabetic clinic should have a social service adequate for contact with every patient. But many of the diabetic clinics in the city have no social service and others refer only an occasional patient to the general social service department. About half of the hospital patients with diabetes in the census of the chronic sick were not known to a social worker. This subject has been discussed more fully in another section of the report.[2] Among 23 diabetic clinics of the city, in which inquiry was made, a great variety was found in the arrangements for providing social service. One clinic had no social work. Half of the remainder had the services of a social worker, sometimes for half or three-quarters of her time, and in 8 clinics, the social worker was present during all sessions of the clinics. The other half referred special problems to the general social service department.

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(1) Address by William B. Seltzer, Minutes of the Meeting of the Medical Social Service Section of the Welfare Council of New York City, March 11, 1931, p. 2.
(2) The Special Problems of Some Main Groups of Chronic Diseases. A Section of the Study of the Provision for Care of the Chronically Ill in New York City, by Mary C. Jarrett. Research Bureau, Welfare Council of New York City, May, 1932, Mimeographed copy, p. 141.

The need for increase and improvement in social service for patients with cancer has been discussed in the section dealing with that disease.(1) Of nearly 500 cancer patients in hospitals in the census, about 60 per cent were not receiving any attention from a social worker. The municipal cancer hospital has a well organized social service department and the Director of the Division of Cancer in the Hospital Department has expressed his belief that "in no other branch of health service is the social worker more essential" than in the treatment of cancer.(2) One of the objects of the Brooklyn Cancer Welfare Service, a recently organized committee of Brooklyn women, is to promote medical social service for patients with cancer where it is needed. The New York City Cancer Committee has directed attention to the need for an increase of social service for both hospital and clinic patients.

All orthopedic hospitals and clinics in the study have some form of home service, but it is frequently limited to a nursing service for follow-up and does not attempt intensive social case work. The necessity for the latter service was emphasized in the report of the Massachusetts survey of the care of crippled children, in 1931. In regard to nearly a thousand children who needed treatment and were not receiving it, the report states: "The difficulty seems to lie with the lack of adjustment of the families, in which there are crippled children, to the complete system of

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(1) The Special Problems of Some Main Groups of Chronic Diseases. A Section on the Study of the Provision for Care of the Chronically Ill in New York City, by Mary C. Jarrett. Research Bureau, Welfare Council of New York City, May, 1932, Mimeographed copy, p. 93.
(2) Kaplan, Ira I., B. S., M. D., The Social Service Worker's Responsibility in Cancer Work. Hospital Social Service, September, 1931, vol. 25, No. 3, pp. 195, 196.

treatment which exists. Lack of adjustment can be remedied by the establishment of specialized social service for crippled children. Medical social service has developed to a certain standard in the adjustment of the patient to the hospital, and the proper follow-up of the patient on leaving the hospital. This service for crippled children has not been sufficiently developed. It calls for a special technical knowledge of the possibilities of treatment, and particularly an appreciation gained from experience with the attitudes of parents and children toward treatment."(1)

The value of medical social service in the treatment of arthritis has been demonstrated at the Robert B. Brigham Hospital in Boston, which is one of the few modern chronic hospitals in the country and is devoted particularly to arthritis. It has a staff of two trained social workers for approximately 350 patients a year under care in both wards and out-patient department.(2) At the end of the year 1929, there were 96 patients receiving intensive social service to keep them "at their best levels --as far as possible from needing any return of chronic hospital care." It is clear that this type of social work is impossible with the facilities reported by a number of New York arthritis clinics in which inquiry was made. In some of them, special problems were referred to the general social service department; in one hospital, a social worker gave half time to the clinic which sometimes had as many as 150 arthritis patients at a session; in another hospital, one social worker covered other clinics in addition to the arthritis clinic.

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(1) Final Report of the Department of Public Welfare Relative to the Number and Care of Crippled Children, House Document No. 401, Commonwealth of Massachusetts, December, 1931, pp. 47, 49.
(2) Annual Report of the Robert B. Brigham Hospital, Boston, 1929, p. 22.

The treatment of drug addiction, after the first withdrawal of the drug under medical supervision, depends upon psychiatric and social service. The Mayor's Committee recommended a staff of social workers as essential in an institution for the rehabilitation of narcotic users.(1)

The trend of modern medicine is more and more toward the conception that the physician treats not merely a diseased section of the body but the whole person. The director of the study made by the Commission on Medical Education pointed out that "the content and scope of medical training are in the process of undergoing significant changes....Greater emphasis is being placed in some of the schools in study of the patient as a whole, in which factors of emotional life, conditions of employment, habits of living, family life, and other human factors are considered in arriving at a diagnosis or in outlining treatment."(2)

In agreement with this conclusion is the following statement by the director of the new medical center of the New York Hospital-Cornell Medical College Association: "If the medical student is to gain in interest and enthusiasm for the broader social opportunities that surround the doctor, he must be brought in contact with hospital social work practised by professional and scientific methods. It is essential that he should not only be brought in contact with it, but should participate in its performance

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(1) Report of the Mayor's Committee on Drug Addiction to the Hon. Richard C. Patterson, Jr., Commissioner of Correction, New York City. Reprinted from the American Journal of Psychiatry, vol. 10, No. 3, November, 1930, pp. 446-7.
(2) Rappleye, W. C., M. D., Current Problems of Medical Education. The Journal of the American Medical Association, vol. 94, No. 13, March 29, 1930, pp. 915-7.

in order that his social and human development may take place beside his technical and scientific training....the doctor must view man as body and mind inseparable and must know him in his human surroundings as well as in his physical world if he is to render service of the highest type. It is here that social service has a role to play in medical education. It may be an important factor in shaping the destinies of our doctors of the future."(1)

It follows that social factors should be dealt with as definitely and systematically as medical factors. A major function of the social service therefore is to take part in the original study of the patient. To quote from a report of the American Association for Hospital Social Workers:

"Such inquiry is not the chance discovery of episodes in the patient's past life or of his present needs and desires. It is a deliberate, methodical undertaking, directed to specific ends. It takes place by direct observation on the part of the inquirer, and by the securing of testimony from the patient himself and from others associated with him. It should reveal all the facts essential to a knowledge of the meaning of his sickness and the means he has, or lacks, for meeting his disability. It may be brief or extended. Even a brief inquiry, planned and carried out with enough precision to give facts which make the main issues clear will save much waste motion for patient and for hospital."(2)

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(1) Robinson, G. Canby, M. D., An insert in Better Times, vol. 14, No. 6, November 7, 1932, p. 15.
(2) The Functions of Hospital Social Service: A Report of the Committee on Functions. American Association of Hospital Social Workers, Monograph No. 1, June, 1930, p. 60.

The social factors that may affect the health of patients have been classified in the report on the functions of a hospital social worker quoted above, as follows:

"1. Social conditions which bear directly on the health of the patient, either inducing susceptibility to ill-health, or helping or hindering the securing and completing of medical care.

2. Social distress caused to others by the illness of patients; such as, loss of income, neglect of children, etc.

3. Social problems not having direct cause-and-effect relation to the health condition, but collateral to it. Such problems would exist independently of the sickness." It is pointed out that "these factors exist in many possible combinations."(1)

It is clearly the function of the hospital social service to deal with factors of the first group in direct service to the patient. As a rule factors of the second and third groups in a well-organized community are primarily the function of specialized agencies and are dealt with through cooperative relations with these other agencies. Frequently a combination of these direct and indirect services is required for the same patient. Also in problems of the first group other agencies must often be called upon for special services. In any case it is the responsibility of the medical social worker to see that the patient's social problems are handled in a way to promote his medical care, and therefore, she must learn from the physician the exact nature of the disease process and its possible consequences; and if different parts of the body are affected, she must learn how

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(1) The Functions of Hospital Social Service: A Report of the Committee on Functions. American Association of Hospital Social Workers, Monograph No. 1, June, 1930, p. 59.

the various disease processes are interrelated. It has been aptly said: "It is the part of good medicine to synthesize as well as to analyze the patient, and the social worker must ask no less of the physician."(1)

When the treatment of the patient's social problems is carried on through a cooperative relationship with another agency, the medical social worker must not only be able to give practical and intelligible information about the patient's physical condition to the agency but must also have enough detailed knowledge of the functions and facilities of the agency to judge whether the application is well placed. To make two or more agencies work together for the good of a patient requires not only knowledge of all factors in the situation but also considerable skill. It is generally recognized that policies for such cooperative work should be worked out by the hospital social service departments and the social agencies of different types based upon fundamental principles of social organization. The Medical Social Service Section and Family Service Section of the Welfare Council through a joint committee have agreed upon policies to be tried experimentally.(2) In Cleveland, similar efforts have been made to formulate policies for children's agencies cooperating with hospitals.(3) The Children's Hospital in Boston has successfully developed foster home care for convalescent

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(1) Cannon, Mary Antoinette, Approach to Social Case Work in the Hospital. Hospital Social Service, vol. 10, No. 4, October, 1924, p. 172.
(2) Byington, Margaret F., On Division of Labor. Better Times, vol. 13, No. 18, February 1, 1932, p. 15.
(3) Peck, Gracil Green, The Inter-Relationship of the Medical Social Worker and the Children's Workers of the Non-Medical Agency. Bulletin of the American Association of Hospital Social Workers, vol. 5, No. 1, January, 1932, p. 10.

and chronically ill children through its agreements with certain children's agencies. In New York, the Heart Committee is studying the possibilities of foster home care for cardiac children.

Among other types of agency with which hospital social service departments must frequently cooperate are convalescent homes, visiting nurse services, sheltered workshops, and employment centers for the handicapped. In most instances, the social service department attempts to conform to the policies of the other agency without further effort to arrive at an agreement by which both agencies working together may accomplish the best result for the patient. For example, the Employment Center for the Handicapped furnishes other agencies with a clear and comprehensive statement of the types of handicapped persons it serves, and the social service departments refer such patients to the center. A well-defined cooperative relationship here would show the need for some knowledge of vocational guidance for the handicapped on the part of the medical social worker, not in order to give vocational advice or make the placement but to help the patient to adjust himself to his disability and to prepare him for placement. She needs to know the requirements of different occupations and processes in industry in order to judge how the patient's special skill and experience may be conserved and adapted to a new job.

Whether the service given by the hospital social worker involves intensive medical social treatment, a cooperative relationship with another social agency, or some special bit of advice or assistance, the characteristic that gives it professional value is that it should be done in the light of the patient's total welfare. This has been well put by Miss M. A. Cannon: "The giving of a single service, piece of information, explanation

or recommendation is of value in proportion as it rests upon a truthful analysis of some person's need, and so applies the individual or case method to an individual. Case workers in the hospital can save waste that comes from routine, therefore indiscriminate, handling of individual patients. By application of case method even the smallest piece of work may be made to fit into place in a complete plan of treatment."(1)

As social work has come to be recognized as essential in medical diagnosis and treatment, it naturally follows that one function of a social service department is to contribute to medical research. This subject is discussed further on in connection with the facilities for medical social service in this city. The College of Surgeons in recommending follow-up for certain chronic conditions - cancer, cardiac and renal disorders, tuberculosis, arteriosclerosis - in order to "enrich scientific knowledge as to diagnosis and treatment and promote the prevention of disease" pointed out that "such follow-up and desirable results cannot be successfully assured without a well organized social service department."(2)

So far, medical social work has been identified almost entirely with medical institutions and has extended only in rare instances into public health agencies. Massachusetts for a number of years has been developing social service in the State Department of Public Health, first in its venereal disease program and later in connection with the control of cancer and tuberculosis, and has given consideration to the place of social work in

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(1) Cannon, Mary Antoinette, Approach to Social Case Work in the Hospital. Hospital Social Service, vol. 10, No. 4, October, 1924, pp. 172-3.
(2) American College of Surgeons, Hospital Standardization Report for the Year 1931, Chicago, p. 31.

relation to the control of other chronic diseases.(1) The role of the medical social worker in public health has not yet been evolved. Although much thought and discussion has been given to cooperative relations and differentiation of functions between public health nurses and medical social workers, and effective working relations have been developed in many local situations, the principles and policies differentiating the responsibilities of these two groups are not yet clearly defined. This issue has been briefly stated as follows: "It is of course obvious that at many points these fields overlap and that either worker may have a considerable degree of knowledge and experience in the field of the other. The important point is that a major responsibility should be assumed by either worker in the field in which her training and experience give her the right to speak with some degree of authority. It is in the region in which both groups recognize an interest and some degree of responsibility that the necessity for clarification becomes necessary."(2) The White House Conference report states that "leaders in both public health nursing and medical social work agree that this problem should receive more thoughtful study" and finds that "there is a serious need for thought and discussion on this subject."(3)

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(1) Kelly, Eleanor E., The Social Worker in Adult Hygiene. The Commonhealth, vol. 16, No. 4, December, 1929, pp. 129-133.
(2) Byington, Margaret F., Team Work Between the Nurse and Social Worker. Public Health Nursing, vol. 24, No. 1, January, 1932, p. 14.
(3) Hospitals and Child Health. Report of the Sub-committee on Medical Social Service at the White House Conference on Child Health and Protection, pp. 188-189. New York, The Century Company, 1932.

II

CHRONIC PATIENTS RECEIVING SOCIAL SERVICE IN THE HOSPITALS STUDIED

In the census of the chronic patients in hospitals made for this study, the question was asked: "Is the patient under care of the medical social service?" The nature and extent of the service rendered are questions beyond the scope of the study. Special case studies would be necessary for such an evaluation of the service. The information obtained in the census therefore indicates that the patient was known to a social worker in the hospital but does not show the extent of this knowledge or the quality of the care given. The service given may range from an interview with a relative concerning the patient's care or a report of his condition to another social agency to intensive case work in studying a patient's situation and carrying out over a period of months a plan for his future care or occupational rehabilitation.

There were 96 private hospitals and 21 public hospitals in the city, exclusive of special hospitals for the types of illness not covered by this study, that is tuberculosis, mental diseases, and diseases of the eye and the ear. Thirty-eight of the 96 private hospitals and one of the 21 public hospitals had no social service.

Eighteen of the 77 public and private hospitals included in which the census of the chronic sick was taken had no social service, including

one public orthopedic hospital with two per cent of all the chronic patients in hospitals, 7 private chronic hospitals with 14 per cent, and 10 private general hospitals with one per cent. The records of 29 per cent of the chronic patients in hospitals with social service did not contain the information as to whether or not the patient was known to the social service. This information was obtained for a much larger proportion of patients in private hospitals (93 per cent) than in public hospitals (56 per cent). It is believed, however, that the records of chronic patients in public hospitals for whom this information was reported, although less than three-fifths of the whole number, fairly represent the whole situation in regard to the extent to which chronic patients are receiving social service in the municipal hospitals.

The 59 hospitals with social service reported 4,595 patients, of whom 63 per cent were said to be under the care of the social service department. Although a chronic disease almost invariably constitutes a social problem, 37 per cent of these patients were not even known to a social worker in the hospital. In Table 1, the proportion known to the social service in different types of hospitals is shown, together with the percentage of all the chronic patients for which the item was reported. All or nearly all of the chronic patients were known to the social service in 5 hospitals, which included a cancer hospital, a contagious hospital reporting 5 chronic patients, two public general hospitals with chronic services, and a private general hospital.

Table 1. Percentage of patients known to the social service in public and private hospitals of each type

Hospitals	Per cent reporting	Known to social service	Not known to social service
Total	70.8	63.1	36.9
Public	56.0	49.9	50.1
General	45.0	68.4	31.6
Special	58.6	100.0	0.0
Chronic	99.8	0.8	99.2
Private	92.7	74.9	25.1
General	89.3	58.6	41.4
Orthopedic	97.4	90.0	10.0
Chronic	94.9	90.9	9.1

In the private hospitals less than half of all the chronic patients were known to the social service. There was no social service in 17 of the 57 private medical institutions covered by the census. In institutions in which there was a social service department, three-fourths of all the chronic patients were known to a social worker. Ninety per cent in chronic and orthopedic hospitals and less than 60 per cent in general hospitals were known to the social service.

In public hospitals, 48 per cent of the adults and 80 per cent of the children were known to the social service. All for whom the item was reported were known to the social service in the special hospitals; practically all in the chronic hospitals; and 68 per cent in the general hospitals.

The percentage of children (85 per cent) known to the social service was much larger than the percentage of adults (69 per cent). The

proportion of patients in different age groups known to the social service in both public and private hospitals is shown in Table 2.

Table 2. Percentage distribution of patients known to the social service in public and private hospitals, each age group

Age	Total		Public			Private		
	With social service	Without social service	Per cent reporting	With social service	Without social service	Per cent reporting	With social service	Without social service
Total..	63.1	36.9	56.0	49.9	50.1	92.7	74.9	25.1
Under 16..	85.0	15.0	38.3	80.0	20.0	95.5	85.6	14.4
16-39.....	63.6	36.4	55.5	50.2	49.8	91.7	70.8	29.2
40-59.....	58.6	41.4	57.3	47.8	52.2	92.8	71.3	28.7
60-69.....	50.4	49.6	55.5	47.9	52.1	89.0	56.6	43.4
70 years and over..	52.8	47.2	60.4	48.4	51.6	84.5	71.8	28.2

The proportion of chronic patients not known to the social service increases almost consistently with each age group in both public and private hospitals.

The extent to which hospital patients with different forms of chronic disease were receiving social service, is shown in Table 3.

Table 3. Percentage of patients known to the social service in hospitals, certain diseases

Type of disease	Children			Adults		
	Total	Known to social service		Total	Known to social service	
		Number	Per cent(1)		Number	Per cent(1)
Orthopedic disorders	551	351	63.7	245	103	42.0
Poliomyelitis	165	152	92.1	32	22	68.8
Rickets	33	29	87.9	0	0	...
Congenital malformations	53	33	62.3	14	5	35.7
Diseases of bones and organs of locomotion	115	64	55.7	143	47	32.9
Tuberculosis of spine or joints	185	73	39.5	56	29	51.8
Diabetes	6	5	83.3	104	42	40.4
Cancer	6	1	16.7	485	201	41.4
Diseases of digestive system	6	3	50.0	136	54	39.7
Diseases of skin	8	4	50.0	134	48	35.8
Heart disease	86	50	58.1	558	186	33.3
Arthritis or rheumatism	37	29	78.4	426	126	29.6
Fractures	31	12	38.7	177	69	39.0
Nephritis	16	8	50.0	105	29	27.6
Neurological diseases	66	47	71.2	1,113	292	26.2
Old age	0	0	...	248	51	20.6

(1) Based upon the total number with the given diagnosis reported by hospitals.

Less than half of the adults in each disease group were known to be receiving social service with the exception of those suffering from the results of poliomyelitis and non-pulmonary tuberculosis. In nearly every group, children received attention from the social service more frequently than adults.

Table 4 shows the types of care needed for the chronic patients known to the social service department; that is, whether their condition called for medical study and treatment, nursing care by a trained nurse, or attendant care by a skillful but not necessarily trained person.

Table 4. Care needed by patients known to the social service in hospitals, each age group

Care needed	Total	Under 16	16-39	40-59	60-69	70 and over	Not reported
Total.....	2,053	564	432	599	250	197	11
Medical.....	1,406	515	321	376	125	67	2
Hospital.....	1,080	296	281	334	103	64	2
Clinic.....	326	17	40	42	22	3	0
Nursing.....	122	32	29	42	22	12	0
Attendant.....	516	0	81	180	97	118	8
Not reported.....	9	0	1	1	6	0	1

The large majority were patients needing medical care, which could be given in clinics for nearly a fifth, mainly children. Nearly a fourth of the whole number needed attendant care and a small proportion nursing care.

Three-fourths of these social service patients were receiving the type of medical or nursing care suitable for their condition and were being cared for under satisfactory conditions at the time of the census, as shown below in Table 5.

Table 5. Present situation of patients known to the social service in hospitals, each age group

Present situation	Total	Under 16	16-39	40-59	60-69	70 and over	Not reported
Total.....	2,053	564	432	599	250	197	11
Suitable care.....	1,535	318	358	519	202	129	9
Unsuitable care.....	508	246	73	79	42	67	1
Not reported.....	10	0	1	1	6	1	1

A fourth were not receiving satisfactory care, of whom nearly half were children requiring clinic care.

III

MEDICAL SOCIAL SERVICE FACILITIES IN NEW YORK CITY

Since there is no differentiation in the records of medical social service departments between work in behalf of the acutely ill and of the chronically ill, the social service facilities of hospitals have been treated as a whole in the discussion that follows. It is probably true that patients with chronic conditions, including both clinic and ward patients, demand the greater part of these facilities; but no estimates of the division of service between chronic and acute patients are available and the situation would naturally vary according to the nature of the hospital's medical work. The object of this discussion of medical social service facilities is to present available information showing the amount and character of the medical social work done in the hospitals of New York, since it is assumed that these are factors of fundamental importance in the community's care of the chronic sick both in relation to the prevention of illness and disability and also in relation to the provision of economical and kindly care for chronic invalids.

No general survey of hospital social service departments, such as was made recently in Philadelphia,(1) has been made in New York City. The present study of these facilities included 55 departments, mainly those

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(1) Social Service in Hospitals and Dispensaries: Chapter 18 of Philadelphia Hospital and Health Survey, 1929, by Haven Emerson, M. D., Sol Pincus, and Anna C. Phillips. Sponsored by the Philadelphia Chamber of Commerce. Published by the Philadelphia Hospital and Health Survey Committee, 1930.

in hospitals in which the census of the chronic sick was taken, and covered items related especially to the care of chronic patients. (See pages 56 to 64.) The annual reports of the social service departments indicate that there is great variation in the proportion of patients served and in the character of the services rendered. Two departments with about the same number of social workers report respectively about 1,900 and 7,000 patients. Three other much larger departments with comparable staffs report approximately 650, 5,000, and 7,000 patients. One of the latter group reports 3,000 home visits and another 245 home visits. Most of the reports make no attempt to interpret or evaluate the quality or usefulness of the service. It may be assumed that most of it comes within the category usually defined in statistics of medical social work as "slight service;" for an examination of the records in the Social Service Exchange of the number of cases registered by six social service departments selected at random, during the year 1930-31, indicates that each had registered a small proportion of its patients. All of these departments together report nearly 23,000 patients dealt with in the course of a year; and yet in the year cited all six registered only 2,230 patients. It may not be practicable to clear all clinic cases in the Social Service Exchange; but no definite or uniform principle seems to have been established for selection of the cases to be cleared.

Standards and Coordination

a) Agencies Engaged

The agency for standardization and development of medical social work in New York City is the local branch of the national professional organization of medical social workers, the North Atlantic District of the American Association of Hospital Social Workers. The agency for coordination in this field is the Medical Social Service Section of the Welfare Council, representing 96 social service departments. Another local organization, the Hospital Social Service Association, composed of member agencies represented by both social workers and lay committee members was organized in 1912 to stimulate the growth of social work in hospitals and dispensaries and to standardize such work. It publishes a monthly magazine, "Hospital Social Service", which has a national circulation. As other local and coordinating agencies in the field of social service have developed, its local activities have diminished and it is now known chiefly for its publication of the outstanding magazine in the field of medical social work. The New York Tuberculosis and Health Association also brings together social workers in different medical fields in conferencesfor educational purposes. The Associated Out-Patient Clinics Committee of this organization had a sub-committee on medical social service which united with the corresponding section of the Welfare Council when the latter was organized.

The North Atlantic District of the American Association of Hospital Social Workers, with headquarters in New York, covers the eastern half of New York State, all of Connecticut, and the northern half of New Jersey. Its object is to work toward improvement and development of standards

of social work among its membership in the hospitals and within its territory. For the past two years, it has conducted institutes for its members, consisting of conferences under the direction of a leader.

The Associated Out-Patient Clinics of the City of New York was organized in 1912; and, at the instance of the Public Health, Hospital and Budget Committee of the New York Academy of Medicine, its statement of purpose in promoting proper standards of treatment provided for "the study of the relative need of home visiting and of social service in the different departments of a general dispensary, with a view to the encouragement of development of such work along the lines of greatest immediate need and benefit."(1) Although the Medical Social Service Section of the Associated Out-Patient Clinics was not organized until 1921, in the standards set up for each of the medical sections there was always a recommendation that the clinics be equipped with social service, preferably by having social workers a part of each clinic's personnel, or that service should at least be available from a general social service department in the hospital. Early in 1926, this association, which had been merged in 1920 with the Committee on Dispensary Development of the United Hospital Fund, became the Associated Out-Patient Clinics Committee of the New York Tuberculosis and Health Association. In 1927, its Medical Social Service Committee became the Executive Committee of the Medical Social Service Section in the Health Division of the Welfare Council.

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(1) The Associated Out-Patient Clinics of the City of New York, First Annual Report, 1913, p. 9.

This Section of the Welfare Council, in which 99 agencies are represented,[1] meets about six times a year. The requirements for agency membership in the Section are: a) a responsible and active governing body, b) a legitimate purpose concerned with medical social service, c) reasonable efficiency, and d) a willingness to cooperate with other members in preventing duplication of work and in promoting other essential objectives of the Welfare Council. The Section has committees on the division of labor between family and medical social agencies, the development of social service in eye clinics, the use of the Social Service Exchange, problems of venereal diseases, extension of medical social service to meet the needs of the chronic sick, and relief problems in hospitals; and it has recently organized a lay committee composed of members of auxiliaries and advisory committees of medical social service departments.

b) Standards of Organization

The American Association of Hospital Social Workers adopted in 1928 a statement defining the minimum standards to be met by social service departments in hospitals. It is assumed that a hospital organizing a social service department under that name is under an obligation to meet certain accepted standards. The fundamental requirements are: 1) that since the primary purpose is "to further the medical-social case study and treatment," "the major activity of the department should be medical-social case work;"

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(1) These 99 agencies include 96 medical social service departments, 1 medical research institute, the Central Council of Social Service Auxiliaries, and the Hospital Social Service Association of New York City.

and 2) that since "it is important to the hospital that its medical and social work be closely integrated in function and organization," the department should function "as an integral part of the institution."(1) These minimum standards were embodied in full in the Hospital Standardization Report, 1930, of the American College of Physicians and Surgeons.

A more detailed outline of standards of social work in hospitals together with suggestions for putting them into practice had previously been prepared, in 1926, by a Committee of the Social Service Section of the Associated Out-Patient Clinics of New York City and published in pamphlet form under the title "Technique of Hospital Social Service." The Committee offered this statement "not as a final word on the subject, but as a convenient basis for further discussion and experiment which may eventually lead to constructive and comprehensive standards of hospital social service practice."(2) Six years later, however, few of the 96 social service departments of the city have been able even to approximate either the standards here outlined or the minimum standards adopted by the American Association of Hospital Social Workers.

As mentioned above, the cardiac clinics have come nearer to a general standard of social work than any other medical unit, in that the

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(1) A Statement of the American Association of Hospital Social Workers which Defines the Minimum Standards to be met by Hospital Social Service Departments, Adopted May, 1928. Bulletin of The American Association of Hospital Social Workers, July, 1928, pp. 1-2.
(2) Technique of Hospital Social Service. Prepared by a Committee of the Social Service Section, The Associated Out-Patient Clinics of the City of New York, February, 1926, p. 4.

standards outlined by the Committee on Cardiac Clinics[1] and accepted by a majority of the clinics require that there shall be a social worker in each clinic whose duties and responsibilities are defined.

c) Professional Training

The national organization, the American Association of Hospital Social Workers, has sought to influence standards for personnel. It has continually endeavored to raise its requirements for membership; but these requirements are still very broad. Graduation from a recognized school or social work with special experience in medical social work is accepted as the standard for membership. However, 5 years of experience in social work is accepted as a substitute for regular training; and for those who have had nursing training only three and a half years of experience in social work is required. These membership requirements embrace a wide range of personnel. The medical social worker who has graduated from a school of social work may have been through college and received two years of post-graduate education in the theory and practice of medical social case work. At the other extreme is the social worker or nurse without special education in medical social work, who may not have received as much as a high-school education and who qualifies for membership only through practical experience acquired in many instances under a supervisor who is also without training in social work. As the association has no

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(1) Standard Requirements for a Cardiac Clinic. Prepared by Committee on Cardiac Clinics of the Heart Committee of the New York Tuberculosis and Health Association, Inc., October, 1931, pp. 7-8.

means of evaluating this experience, the membership is greatly diversified in regard to background and ability.

No common standards of training for medical social workers are generally accepted in New York City. In the selection of social workers for hospitals and clinics, there is no general recognition of the qualifications required for membership in the American Association of Social Workers. Some of the workers in the social service departments do not meet even the widely inclusive membership requirements of the American Association of Hospital Social Workers. Only a few of the private hospitals will appoint a social worker without nurse's training, but very few require recognized social work training. The development of hospital social work in New York was initiated by the nursing group, in contrast to other communities where it grew out of social work. Nursing education, therefore, was assumed to be the primary requisite for hospital social work; and social workers were considered ineligible regardless of the extent of their medical-social training. It is only within the last ten years that workers other than nurses have been accepted in any of the social service departments of New York hospitals. In the municipal hospitals, it is still an invariable requirement that the staff of the social service departments shall be nurses and the requirements for experience in social work are poorly defined. Presbyterian Medical Center requires medical social training without regard to whether the social worker has or has not had nurse's training. Mt. Sinai Hospital also gives preference to persons who have had special training in medical social case work.

"In 66 or one-sixth of the 430 social service departments listed by the American Association of Hospital Social Workers in 1924, the head worker bears after her name upon the list the letters R. N. ("Registered Nurse"). In the remaining 364 she has had no such designation, and if she has had nurse's training probably considers it less important than the social training which she has also received. Thirty of the 66 registered nurses just referred to belong to hospitals within New York City, in which, following the example of Bellevue Hospital, it has until recently been the custom to consider that the training of a nurse was in itself nearly or quite sufficient to qualify one for social work. This point of view, however, has never been held in other parts of the country and is beginning to be abandoned even in New York."(1)

The first training course in medical social work was organized in 1912; but for the first ten years or so, the growth of such courses was slow and there was little coordination with the field of practice. The American Association of Hospital Social Workers formed its Education Committee in 1925 for the purpose of fostering relations between the schools of social work and the practitioners. "Of the 28 schools now belonging to the Association of Schools of Professional Social Work, 10 offer training for medical social work and in another plans are going forward for such training....In most of the schools an undergraduate degree is required for admission. Where the degree is not obligatory, at least two college years,

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(1) Cabot, Richard C., M. D., Hospital and Dispensary Social Work. Hospital Social Service, vol. 18, No. 4, October, 1928, pp. 308-9.

or its equivalent, is required, and in addition evidence of other education more or less formal in character. Completion of medical social training in most of the schools gives academic recognition to the degrees of A. M. or M. S. The fact that medical social training is classified in all schools as graduate work means that standards in all parts of the training plan must meet requirements for graduate work in universities."(1)

It is well known that in many hospitals in New York and elsewhere little consideration is given to professional education for medical social work in the selection of the social service staff. Although it is now ten years since the American Hospital Association appointed a committee of eighteen representative physicians, nursing educators, hospital social workers, and educators in general social service to study the subject of training for hospital social service and to make recommendations, which were adopted and published,(2) many hospital administrators and boards have not yet given consideration to the standards of education for social workers recommended in the Committee's report.(3)

Probably this indifference to special preparation for medical social work by many hospital authorities is due to their failure to realize exactly the nature of the duties and responsibilities of the social worker,

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(1) Hospitals and Child Health: Report of the Sub-Committee on Medical Social Service at the White House Conference on Child Health and Protection, pp. 197-8. New York, The Century Company, 1932.
(2) Report of the Committee on Training for Hospital Social Work Appointed by the American Hospital Association, Inc., Bulletin No. 55. American Hospital Association, Inc., 1923.
(3) See Appendix I for a brief outline of the standard course recommended for medical social workers by this committee of the American Hospital Association, Inc.

as Robert M. Mac Iver has suggested in a remarkably lucid account of the nature of a social worker's functions. He says: "I have dwelt on the magnitude of his function, because until it is realized more generally he cannot gain the status necessary for its performance. The old ideas still linger in the public mind though the old order has passed. Even in the minds of many social workers it still lingers, in the minds of those, for example, who think that apprenticeship is an all-sufficient training for the work they have to perform. Do they not know that in every other sphere of worthwhile endeavor - except perhaps, and unfortunately, politics - the day when apprenticeship suffices is past? Important, even necessary as it was and is, it provides only the foreground of the social worker's training."(1)

A number of reasons may be given for the fact that many physicians still do not have the conception of medical social work as a service requiring trained professional skill. The term "medical social worker" is used loosely to apply to persons differing widely in education and ability. The salaries paid are frequently too low to attract professionally trained persons; for example, in Philadelphia 75 per cent of the social workers in hospitals in 1929 were receiving less than $1800 a year and 90 per cent less than $2100 a year.(2) In many hospitals because of too small a staff, the trained social workers are obliged to perform a variety of duties which are not medical social work but rather assistance in administration. Under these conditions, it is natural that convincing demonstrations of the value

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(1) Mac Iver, Robert M., The Contribution of Sociology to Social Work. New York School of Social Work Publications, 1931, p. 80.
(2) Emerson, Haven, M. D., and others, Philadelphia Hospital and Health Survey, 1929. Published by the Philadelphia Hospital and Health Survey Committee, 1930, p. 801.

of medical social work as a professional service are still confined to a comparatively limited number of centers throughout the country.

d) Staff Required

No satisfactory estimate of the number of social workers needed in relation to the number of admissions has yet been made that is generally applicable. The proportion of patients requiring social attention and also the amount of attention required per patient vary in different types of illness. Other factors such as administrative duties, teaching, contributions to research, also affect the size of the staff. The proportion of children in the hospital's clientele and to some extent the economic level of its patients are other factors to be taken into account. Therefore, general estimates of staff in relation to admissions will show wide variation; and for practical purposes, the percentage of patients who may be expected to have social needs must be estimated for the individual hospital and for each separate service. The conclusion reached by an officer of the American College of Surgeons, after a survey of over one thousand hospitals, was that "there should be one social worker for every 150 to two hundred patients in a mixed hospital caring for free, part-pay, and pay patients."(1) In the Philadelphia Hospital and Health Survey, the desirable minimum for social service as indicated by the usual practice in the best equipped hospitals was found to be one social worker to every 2,000 annual admissions to hospital or clinics.(2)

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(1) MacEachern, Malcolm T., Ratio of Hospital Personnel to Patients. Bulletin of the American Hospital Association, vol. 4, No. 10, October, 1930, p. 16.
(2) Emerson, Haven, M. D., and others, Philadelphia Hospital and Health Survey, 1929. Published by the Philadelphia Hospital and Health Survey Committee, 1930, p. 805.

At the time of this study in 1928, there were 47 social workers in the 42 cardiac clinics represented in the Committee on Cardiac Clinics or one social worker to 250 patients under treatment. The variation in different clinics was from one social worker to 36 patients to one social worker to 680 patients.

A study by the staff of the Social Service Department of the Presbyterian Hospital, New York, of 300 cases consecutively discharged from the hospital in 1930, indicates that twenty per cent, in the opinion of the workers, had no need of social service; fifty per cent were of the "self-directing" group who need instruction or interpretation and guidance; thirty per cent presented social problems that had to be met in order to have the patient benefit fully from the medical care.(1)

The ratio between the social staff and the annual admissions in 29 New York hospitals, according to figures published in their annual reports, is shown in Table 6. As the footnotes on the table indicate, there are points in which these figures are not strictly comparable; but they serve to indicate roughly the very great disparity that exists in the relation of social service staff to number of patients in hospitals of various sizes.

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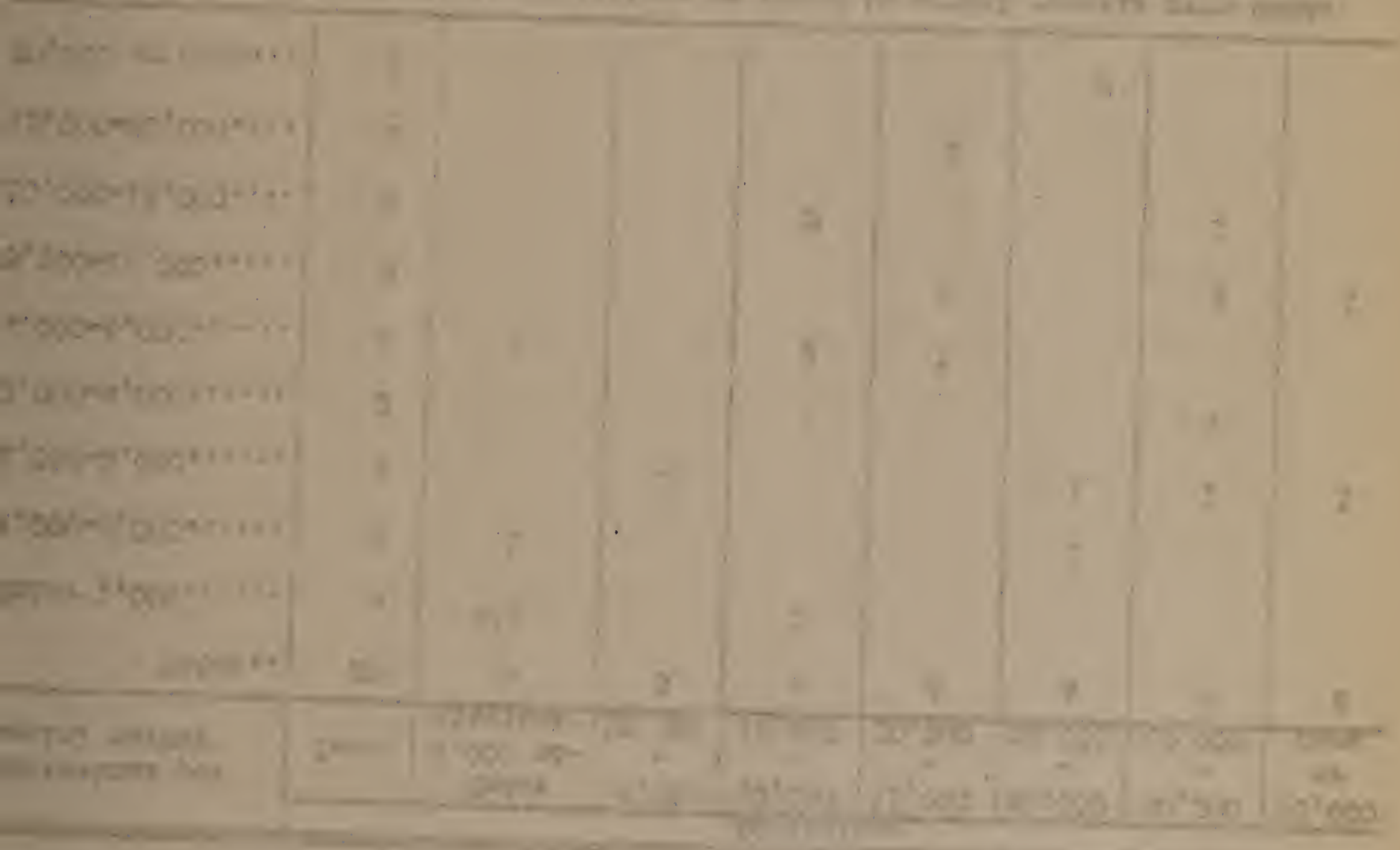
(1) Annual Report of The Presbyterian Hospital in the City of New York, 1930, p. 62.

Table 6. Hospital and clinic admissions per social worker by total admissions,[1] 29 private hospitals[2] in New York City, 1928[3]

Admissions per social worker	Admissions							
	Total	Under 5,000 admissions	5,000 - 10,000	10,000 - 15,000	15,000 - 20,000	20,000 - 30,000	30,000 - 40,000	50,000 or more
Total..	29	5	3	6	4	4	5	2
Under 1,000.....	4	[4]3		1				
1,000-2,000.....	2	1				1		
2,000-3,000.....	6		3			1	1	1
3,000-4,000.....	2			1			1	
4,000-5,000.....	4	1		2	1			
5,000-10,000.....	4				1		2	1
10,000-15,000....	3			2			1	
15,000-20,000....	2				2			
20,000 or more...	2					2		

(1) Total hospital and clinic admissions as shown in annual reports were used. These figures in many cases do not allow for duplication between admissions in various departments of the clinic, or between admissions to the hospital and the clinic.
(2) Selected on the basis of information available in annual reports. Includes 2 chronic, 3 orthopedic, and 24 general hospitals.
(3) In five instances, 1926, 1927, or 1929 figures were used because 1928 figures were not available.
(4) One of these has no clinic service.

Half of these 29 hospitals had a ratio of 1 social worker to 4,000 admissions or over, and more than a third 1 social worker to 5,000 admissions or over. There were only 2 hospitals with 10,000 or more annual admissions that had a ratio of 1 social worker to 2,000 admissions or less. Only 6 hospitals in all had 1 social worker to 2,000 admissions or less. The ratio was one to



less than 1,000 in 3 of the smaller hospitals and in one with over 10,000 admissions.

Although all of the public hospitals except one have some provision for social service, the staff of social workers on the whole is not large enough to care for the needs of chronic patients. It may be assumed that every dependent chronic patient admitted to a public hospital should receive the benefit of an inquiry into his social needs at the time of admission; but 52 per cent of the adults and 20 per cent of the children in our census in public hospitals were not known to the social service. The distribution of this service is very uneven. In one large hospital, 98 per cent of the chronic patients reported were known to the social service, and in another, only 7 per cent were known to the social service. One hospital had a staff of 13 workers and another with nearly as large a bed capacity had only 4 workers in the social service. The municipal hospital for children with tuberculosis of the bones, glands, and joints had no social service department, although it is generally recognized that such an institution, where children may remain for years, should be conducted according to the standards of a child-caring agency with ample provision for social service. In the city homes for the infirm and aged, the provision for social service is deplorably inadequate. (For details see the section of the whole report dealing with municipal institutions.)

Forms of Organization

Various forms of organization were found in the 55 social service departments studied. The department is sometimes financed and administered

wholly by an auxiliary group that is only loosely responsible to the hospital administration. In other instances, the hospital budget provides for a social service department but allows so little that the greater part of the department's budget is raised by an auxiliary group, who to a greater or lesser extent affect its administration. There are a few hospitals, in which the social service is a part of the organization just as the nursing service is and in which the hospital accepts full responsibility for raising the social service budget. This last type of organization does not preclude volunteer committees or workers, who may give important assistance either in raising money or in other capacities. Most of the hospitals have a committee of lay persons with an interest in social service.

As pointed out in the report on medical social work prepared for the White House Conference, "a department of social work should be an integral part of the institution it serves. In a survey made by the American Hospital Association in 1920, 50 per cent of the departments were found to be controlled and financed by the medical institution as a definite department. In our present survey this figure has risen to 89 per cent.....Many social service departments have been inaugurated by auxiliary groups and not by those intimately concerned with hospital administration, such as hospital executives or trustees. These groups have been more or less familiar with other fields of social work and have become aware of the need for social service in a hospital. They undoubtedly have made possible in many cities earlier attention to the social problems inherent in the institutional practice of medicine than would otherwise have occurred.....Departments thus established have not always had well defined policies regarding working

relationships with hospital executives, medical staff and departments of nursing....This type of organization has the advantage of the backing and financial support of a group of people vitally interested in the development of medical social service, but it has the disadvantage of so separating the social service department from the affairs of the hospital that it may be unable to interpret its functions adequately to administrative and medical staffs and to absorb thoroughly the hospitals' traditions."(1)

The study of medical social work conducted a few years ago under the auspices of the American Association of Social Workers in hospitals throughout the country, found the prevailing form of organization to be as follows: "In the majority of hospitals the social service department is now under the administrative direction of the medical director or superintendent. The board of trustees frequently appoints a social service committee, composed of persons from its own membership or outsiders, to serve in an advisory capacity to the department. It assists in interpreting the needs of the social service department to the board of directors, raising additional funds, interpreting to the community the work of the department, and stimulating outside interest in health education and social needs. But its function is advisory, both to the board and to the director of the department."(2)

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(1) Hospitals and Child Health. Report of the Sub-Committee on Medical Social Service at the White House Conference on Child Health and Protection, New York, The Century Company, 1932, pp. 193-4.
(2) Odencrantz, Louise C., The Social Worker. Chapter 9, Medical Social Work, 1929, p. 152.

There seems to be a trend toward the development of another type of auxiliary committee for medical social service departments dealing not with the administration or development of the department as a whole but rather with a special problem, such as tuberculosis or cardiac diseases in children; that is, a committee representing various interests in the community concerned not with the internal problems of the hospital but with the relation of the hospital to community problems. An auxiliary committee of this type may serve as a central committee for a number of hospitals. The Central Social Service Committee for the Municipal Hospitals of Brooklyn is forming a number of divisions to deal with special aspects of disease, including a division on the chronic sick for the development of services for chronic patients in the medical social departments of city hospitals.

The minimum standards adopted by the American Association of Hospital Social Workers, referred to above (pages 27 and 28) contain the following statement in regard to the most effective form of organization: "It is important to the hospital that its medical and social work be closely integrated in function and organization. The Social Service Department, therefore, should function as an integral part of the institution.....The head of the Social Service Department should be a member of conferences called by the director of the hospital, or by the chief of any department, to discuss or to formulate policies pertaining to the social care of the patient and to the community relationships of the hospital."(1)

The Jewish Communal Survey of Greater New York, in 1928, reported

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(1) Bulletin of the American Association of Hospital Social Workers, July, 1928, pp. 1, 2.

that the Jewish hospitals of this city with one exception lacked this approved form of organization of social service: "A serious defect in the organization of social service in nearly all of the Jewish hospitals is the lack of direct participation by the medical staffs, through representation on the advisory or policy-determining committee. Hospital social service should exist primarily as an aid in the medical care of the patient. If it is really to aid in this way, it must be guided closely by the professional staff in charge of patients, as an essential diagnostic and therapeutic aid in certain cases. The existing type of organization of social service at most of the hospitals seems to reflect a conception of it as an half-extraneous service of humanitarian or financial rather than of medical value. Mt. Sinai Hospital is the one exception in the Jewish group. There the medical social workers often make bedside reports in a case to the physician, and members of the medical staff may and do attend meetings of the Auxiliary when problems come up about medical care of patients."(1)

At the request of the lay delegates in the Medical Social Service Section of the Welfare Council who expressed the need for a central forum for discussion of their common problems as distinguished from the problems of the social worker in the hospital, a Lay Committee was organized in 1932. The first action of the committee has been to seek definite information by the questionnaire method concerning the functions and practices of all the medical social service auxiliaries of the city.

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(1) Jewish Communal Survey of Greater New York. Bureau of Jewish Social Research, Health Section, Chapter IV, Hospital Social Service, 1928, pp. 9-10, MS.

The degree to which the social service is integrated in practice with the medical work of the hospital varies in the 55 hospitals included in the study. In some institutions, the social service is a separate department to which doctors refer social problems as they discover them in the course of their treatment of patients. In others, the social worker is a member of the hospital or clinic personnel and social diagnosis and treatment are considered a definite part of the hospital's provision for the care of the patient. The social factors bearing on the medical situation are then regarded as part of the patient's history with which the doctor is equipped, and the social worker may initiate social treatment without waiting for the doctor to discover the existence of a social problem.

An interesting method of bringing the social service into close working relations with the medical work of a general hospital has been in operation at the Beth Israel Hospital in Boston for about two years. The social worker responsible for the service accompanies a resident physician and the senior house officer on weekly ward rounds. Each patient is discussed in turn on the ward. The senior house officer having received an outline of facts relating to the patient's background and environment, emotional factors, and considerations for after care prepared by the social service, presents additional data, such as, a statement of the specific problem and the diagnosis, the patient's physical and mental condition, the prognosis, the probable duration of hospitalization, recommendations for after care, and a statement of the patient's ability to resume activity and the need for limitation of activity if indicated. Following the rounds, the doctor and social worker review the cases together and select those

problems that indicate the greatest need for medical study and treatment. These ward rounds establish the correlation of medical and social treatment and enable the patient to understand and carry through his treatment in an effective way. The hospital benefits by a shorter period of hospitalization, because the patient is referred early and the medical-social plan is made promptly so that the patient is discharged as soon as practicable.(1)

Social service in the municipal hospitals of New York is under the supervision of a General Director of Social Service in the Department of Hospitals responsible to the Commissioner of Hospitals. There are still great differences, however, among the departments in different hospitals both in regard to standards of work and size of staff. The development of social work in these hospitals has been promoted by the efforts of the New York City Visiting Committee of the State Charities Aid Association. Auxiliary committees have organized social service at the request of the hospital authorities in many of the city hospitals. Other special auxiliaries exist for the purpose of assisting the social work in special departments of hospital service. A Central Council of delegates from the social service auxiliaries of the different hospitals, meeting three times a year, has advisory powers in all municipal hospitals. Several other agencies also provide various helpful services to patients through the social service. The Social Service Committee of the Free Synagogue and other Jewish societies maintain Jewish workers in the social service departments of seven city institutions. An account of the social service of the city hospitals is given

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(1) Cohen, Ethel, An Integrated Medical and Social Service. Reprinted from Hospital Social Service, vol. 25, No. 3, March, 1932, p. 223.

in the section of the report dealing with municipal institutions.

The smaller private hospitals in New York often have no social service. This was found to be the case among the thousand hospitals studied by the American College of Surgeons mentioned above. The Hospital Standardization Report of this Association, for 1930, points out that: "It is not occurring to the management of smaller hospitals that they too have problems of a social nature which must be met by a person well trained for the work."(1)

When social service is regarded as a necessary and integral part of the work of a hospital or clinic, the first question to be faced is what proportion of the whole hospital budget should be devoted to this purpose. As expressed by the President of the Presbyterian Hospital: "Any service directly contributing to the medical diagnosis or treatment of the case should be provided as a charge against hospital general funds. Professional nursing is such a service and at least equally is social service. And so the hospital trustee is or should be prepared to budget social service against general hospital income as a necessary expense chargeable to professional care of patients."(2) Five per cent of the whole budget for ward and clinic expense was considered the highest ratio possible in this hospital "without endangering other departments."(2) The total amount spent for medical social service in New York City is at present a wholly unknown figure. The private hospitals do not as a rule segregate in their accounting

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(1) American College of Surgeons, Hospital Standardization Report, 1930, p. 47.
(2) Medical Social Service from the Viewpoint of the Hospital Trustee, by Dean Sage, address at a meeting of the Medical Social Service Section of the Welfare Council, January 30, 1931.

the expense of social service. In many hospitals, the amounts raised by auxiliary committees for this purpose do not appear in the institution's books; and such auxiliary funds often constitute the greater part of the budget of the social service department. The public hospitals segregate and publish their expenditures for social service, but here also the contributions of the auxiliaries are not included and such funds represent a substantial part of the total expense for social service in the city hospitals. It is to be hoped that in the study of income and expenditures of hospitals that has been undertaken by the Research Bureau of the Welfare Council, it will be possible to collect there figures in both public and private hospitals for at least one year and to show how much is being expended annually for medical social service.

The United Hospital Fund in a study of the cost of out-patient service attempted to differentiate the cost of social service but found that "outside auxiliaries, in a large percentage of cases finance and administer the social service departments. Since these funds do not pass through the accounting divisions of the hospitals, there is an inaccurate knowledge of the cost on the part of both the hospital administration and the auxiliary." It was also noted that "hospitals fail to take into consideration the floor space occupied and the light, heat, lunches and other maintenance expenses required by the social service department."(1)

The report on medical social service at the White House Conference stresses the importance of budgeting the cost of the social service as a part of the whole hospital budget: "Support by groups other than hospital

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(1) Babbitt, Henrietta D., Social Service - A Large Item in O. P. D. Expense. Reprinted from The Modern Hospital, October, 1930, pp. 10, 11.

authorities may allow for more rapid expansion than hospital budgets would permit, but it may tend to isolate the department rather than to foster well defined working relationships with other departments of the hospital organization.....It is essential for the members of the social service department to have a sense of financial security in regard to tenure of office, provided their practice is acceptable. A director should also have some assurance that additional workers can be secured at a reasonable rate of growth upon adequate demonstration of need. Budgets depending upon voluntary subscriptions from auxiliary groups may not furnish this sense of security. Hospital budgeting may limit rapid expension of the work, but will probably stabilize the financing of the social service department. With proper demonstration of need, hospital administrators and trustees should see that social service for their patients is adequately staffed as are their medical and nursing services."(1)

Records and Statistics

It is an axiom of social case work that good records and good work go together. The importance of the record of social history and treatment has been generally recognized by medical social workers, but less frequently by the hospital administration. Good recording is expensive and the expense must be justified "in terms of records that are really useful. The art of writing a record depends primarily on the recognition that records are to

(1) Hospitals and Child Health. Report of the Sub-Committee on Medical Social Service at the White House Conference on Child Health and Protection. The Century Company, New York, 1932, pp. 197-8.

be read, not merely filed away."[1] The social records must be good in order to be of use to the medical staff, they must have time and money expended on them in order to be good, and before this support is obtained the hospital administration must be convinced that they are of value; so that a vicious circle is formed until an opportunity arises to demonstrate the usefulness of good social records in some particular part of the medical work of the hospital.

A few years ago a committee of the American Association of Hospital Social Workers drafted a medical social record form which was recommended as meeting a minimum standard.[2] The main features of this form of record are that it states the medical social problem, the tentative plan of treatment, summarizes the medical-social treatment, and when the record is closed gives the reasons for discontinuing treatment and a statement of the situation at the time. There are few social service departments in New York City that have approached this standard. Evidence of this is found in the report of a survey of social service departments made by Dr. Corwin in 1925: "What most of the records needed very badly was a topical arrangement of information under several general headings and the segregation of data in such a way that the details of the investigation would be separated from the main facts about the physical condition of the patient and his economic and social difficulties. Above all there was an apparent need of similarity

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(1) Hamilton, Gordon, Notes on Current Practices in Medical Social Case Recording. Reprinted from The Family, May, 1931, p. 67.
(2) Ibid., p. 72.

in recording the facts, and also in assigning precise meanings to the terms used."[1] Since that time several departments have improved their methods.

The Presbyterian Hospital introduced in 1916 what is known as "the unit history system" of records, in which all information concerning a patient is kept in one place and the history obtained by the social service appears chronologically in the medical record. This type of joint recording serves a two-fold purpose - it keeps the medical problem clearly before the social worker and the social factors pertinent to the medical case are made readily available to the physician, which "must inevitably result in a closer working relationship between the doctor and the social worker and a definite fusion of objectives."[2]

"A Medical Social Terminology"[3] now in use in many hospitals of the country has been issued by the social service department of this hospital as a guide to enable medical social workers to classify the social situations and behavior of patients and as a guide to the precise use of terms.

A discussion of the relation of the social information to the medical record appears below in connection with a description of facilities in the 55 social service departments included in this study. (See page 56.)

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(1) Lewinski-Corwin, E. H., The Desirability of a Uniform Record Card for Hospital Social Service Work. Reprinted from Hospital Social Service, vol. 12, No. 4, October, 1925, p. 185.
(2) Hall, Beatrice, The Social Service Record in the Unit Medical History. Reprinted from Hospital Social Service, vol. 20, No. 1, July, 1929, p. 26.
(3) Hamilton, Gordon., A Medical Social Terminology. Published by The Social Service Department of The Presbyterian Hospital in the City of New York, 1930.

Recording of statistics of the amount of service given in the social service department is necessary in every hospital, but as each department does it according to a method of its own, the volume of work in different departments can not be compared and the total volume of this service in a given community can not be appraised. A few years ago, efforts were begun to develop a method for recording uniform statistics of medical social work on a national scale. In 1928, a Committee on the Registration of Social Statistics, working at the University of Chicago, invited the American Association of Hospital Social Workers to take part in its project. Two years later, in July, 1930, the work of this Committee was taken over by the United States Children's Bureau. The care with which the work has been done is reflected in the following excerpts from a mimeographed handbook issued by the Bureau:

"It has been the aim of the joint committee to formulate a method of statistical recording in the field of medical social work, a method which will enable those who use it to express numerically the volume of medical social work done. The system which is described and defined in this handbook is the result of the efforts of the Committee to evolve a method which is based on the essential character of medical social work and which makes possible its quantitative expression in terms of service rendered in behalf of patients.

"Any method of statistical recording must be adapted to the processes it is intended to measure, and must change as they change. It is evident, therefore, that the problem of evolving a method of statistical recording in medical social work is a continuous one, and that this is only the first of a series of handbooks. Medical social work, as one of the

special fields of social case work, is still emerging, with certain functions crystallized and others not yet clear. However, social case workers have used statistical reports as a service-accounting device ever since social agencies saw the light of day; and community funds and welfare federations have gathered service statistics from an increasing number of agencies and cities in the last ten or twelve years. As these figures are being used for the purposes of inter-agency and inter-city comparisons of the amount of service rendered and its cost, it is imperative that earnest effort be made to develop a method of statistical recording which while it does not measure the qualitative factors and the accepted standards of work, nevertheless takes these factors into account. Since statistics are already being gathered over a wide geographical area, it is necessary to attempt to formulate a method of statistical recording which will yield figures as fundamentally sound and as comparable as possible.

"Statistics in the field of medical social work should be of value in:

"1. Keeping account of the volume of service rendered to patients by medical social service throughout the country.

"2. Showing change in volume of service from time to time; i. e., month to month, and year to year.

"3. Securing facts of value in making comparisons, such as among social service departments, and of medical social work with other fields of case work.

"4. Yielding facts of value in making decisions within the social service department, and by the hospital administration.

"5. Furnishing one means of interpreting the work to those who support it."(1)

This plan for statistics of medical social service is now being used experimentally in a number of hospitals elsewhere but not in New York City. Grasslands Hospital in Westchester County is using it.

The North Atlantic District of the American Association of Hospital Social Workers, in cooperation with the Department of Statistics of the Russell Sage Foundation, for several years carried on a project for central reporting of medical social service statistics. When it was begun in January, 1929, 28 New York City clinics undertook to become a part of the reporting system. As the standardization of reporting proceeded, however, the number of clinics taking part decreased until by the end of 1931 only 15 clinics were reporting their monthly social service statistics. It became increasingly evident, moreover, that these statistics did not constitute a measure of medical social case work, in view of the varying meanings with which the same terms were used in different hospitals, so that the project was discontinued.

The Section on Medical Social Service of the Welfare Council, through its Committee on the Development of Social Service in Eye Clinics is attempting to develop a very simple form of monthly reporting that will show the fundamental facts in the clinic treatment of patients afflicted

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(1) A Tentative Plan for Statistics in the Field of Medical Social Service. Prepared by a Joint Committee of the American Association of Hospital Social Workers and the Advisory Committee on Social Statistics of the United States Children's Bureau, June 2, 1931, pp. iv, v.

with the major eye diseases, which without proper medical treatment and supervision may result in blindness. The purpose is to measure the clinic activities, to serve as a stimulus in raising standards of practice, and to make possible comparisons between clinics that have been heretofore impossible.

A plan for central reporting of statistics of mental hygiene clinics, including a few items in regard to the social work of the clinics, was developed by the Mental Hygiene Section and the Research Bureau of the Council, and has been in operation since January, 1932, with 29 clinics participating.

Research

When social service became available in hospitals, it was natural that doctors carrying on medical research should seek the assistance of the social workers in obtaining facts and observations concerning the patients in their social relationships. It was also natural that the social workers should obtain the help of the doctors in studying the problems arising out of their work. The practice of collaboration between the medical staff and the social service in the study of medical-social problems has now become so general that in plans for a modern medical social service department, provision is usually made for research as a major activity. In some instances, trained research workers have been added to the staff.

It is peculiarly the responsibility of the medical social service to find out what can be done for patients disabled by chronic disease to save them from chronic invalidism. Quoting from the annual report of the social service of the Presbyterian Hospital, 1929, "we are only at the

beginning of learning what we can do in such cases. It is, we believe, a great field for preventive social work." This responsibility was pointed out many years ago by Ida Cannon: "That the treatment of chronic diseases has been distinctly promoted by the assistance of hospital social service departments is without question. The future holds further opportunities for them to contribute to the study of chronic disease in its social incidence and cost, in its loss of working capacity and its frustration of satisfactory living."(1)

The facilities for social service in most of the hospitals in New York City are inadequate for any direct contributions to research. But the annual reports of some of the hospitals give evidence of a trend toward collaboration between the medical service and the social service in research projects. The Presbyterian Hospital has been conducting a study of the significance of social factors in the medical situation. The medical service appointed a representative to take part and the Auxiliary of the social service department provided the funds. Referring to this joint project, the Director of the Department says: "We believe that a measure of clarification must result from the mere display and enumeration of the many lets and hindrances to medical care which are found in the social relationships of an unselected series of hospital cases. Also a number of questions are emerging from the study of these cases as to the influence of discovered

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(1) Cannon, Ida M., Social Work in Hospitals: A Contribution to Progressive Medicine. Russell Sage Foundation, New York, March 1923, p. 77.

deprivations, strains, and shocks in engendering states of ill health."[1]

The social service department of Mt. Sinai Hospital has participated in two medical-social studies recently, one dealing with treatment of children suffering from asthma and the other with the course of the disease in a thousand children with rheumatic fever.

The research program of the cardiac clinics of this city is an example of the dependence of medical investigation upon social service. A number of "Statistical Studies Bearing on Problems in the Classification of Heart Diseases"[2] have been published, since 1926, by The Heart Committee of the New York Tuberculosis and Health Association, which would not have been possible without the assistance of social service in following-up patients and keeping them under treatment. So far, this research has been confined to medical data and the attempt has not yet been made to collect and analyze social data, since the available social service facilities in the cardiac clinics have not been adequate for the task of defining the problems for study, standardizing the terminology, and establishing the necessary criteria for observing and recording facts.

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(1) The Presbyterian Hospital of the City of New York, Annual Report, 1930, p. 67.

(2) Statistical Studies Bearing on Problems in the Classification of Heart Diseases: I. Introduction by Alfred E. Cohn, M. D; II. Etiology in Organic Heart Disease by John Wyckoff, M. D., and Claire Lingg; III. Heart Disease in Children by May G. Wilson, Claire Lingg, and Geneva Croxford; IV. Tonsillectomy in Its Relation to the Prevention of Rheumatic Heart Disease by May G. Wilson, Claire Lingg, and Geneva Croxford. Distributed by The Heart Committee of the New York Tuberculosis and Health Association, New York City.

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Survey of 55 Social Service Departments

The purpose of the survey of social service departments in hospitals made for this study was to find out to what extent medical social service is available for chronic patients. However, since the social work of the hospitals is not organized separately for chronic and acute services, these facilities were studied as a whole and as far as possible related to the data on the chronic patients in hospitals who were reported in the census of the chronic sick as being under the care of the social service. Probably the greater part of the social service required for the chronic sick is needed for the rehabilitation of the large number of clinic patients rather than for hospital patients who are fewer in number and as a rule more seriously disabled; but since the study did not include a census of clinic patients, the medical social service facilities for clinic patients are only incidentally discussed in this report.

The directors of the social service departments in 55 hospitals were interviewed and information gathered concerning the number of workers in each department and their functions and procedures. In Appendix I, hospitals included in the study are listed.

As stated above (page 17), there are nearly 100 private hospitals and 21 public hospitals in New York that care for patients coming within the definition of the chronic sick as used in this study, exclusive of special hospitals for tuberculosis, mental diseases, eye and ear disorders, and maternity service. Two-fifths of the private hospitals have no social service. All of the public hospitals except one have social service. The 55

hospitals selected for study include all public hospitals of the types studied and about 70 per cent of the private hospitals with social service of the types studied.

Three hospitals with departments for home care that give visiting nurse service rather than social service are not included in this section of the report; and the work of these departments is considered in the section dealing with nursing services. They are Memorial Hospital, the New York Orthopedic Hospital, and the Norwegian Lutheran Deaconesses' Hospital. However, in the census of the chronic sick, the patients in these three hospitals who were receiving visiting nurse service were counted among those receiving social service, since the actual service is similar to that given in some medical social service departments.

a) Contact with Patients

Knowledge of a patient's social situation is frequently necessary for a complete understanding of his medical condition and is usually of great assistance in carrying out wise treatment. Although the practice is still some what rare; it is considered advisable by many physicians and social workers that a social worker should interview both ward and clinic patients, or the persons responsible for them, either upon admission or shortly afterwards. The social worker should meet the patient naturally in the course of hospital procedure, and if necessary keep in touch with him during treatment. For chronic patients, who almost invariably have problems of social as well as of medical care, this is especially important. It is particularly desirable to learn as early as possible what the social problems of the chronic patient are, so that plans for social adjustment

and continued treatment can be completed before his discharge.

Less than half of the hospital social service departments studied had any provision for including all ward patients in their service. Of the 55 departments, 26 reported that each ward patient was regularly interviewed and 29 that they were not. Of the latter 29, 26 gave service to ward patients only when requested by the doctor or someone else interested in the patient. The remaining three departments regularly interview certain groups of patients; one, the prenatal and gynecological patients before admission to the hospital; one, the orthopedic, congenital lues, and cardiac patients before admission to the hospital; and one, the cardiac and rheumatic fever patients just before discharge, mainly for research purposes.

Contact with every clinic patient is even more infrequent. Only five of the 53 social service departments in institutions with clinics reported that each clinic patient was regularly interviewed by a social worker. These were the social service department of the House of St. Giles, Lenox Hill Hospital, Brooklyn Hospital, New York City Cancer Institute, and New York Nursery and Child's Hospital. Thirty-one departments interviewed only patients referred to them by the doctors. The remaining 17 departments interviewed every patient among certain groups. Of the 17, 12 served all cardiac patients, both adults and children, one served all cardiac children; all obstetrical patients were seen by five departments; and all children in the pediatric clinics, diabetics, and syphilitics, were seen by three departments. Other groups in which contact was made with every patient by one or two departments were: mental hygiene; tonsils and adenoids; surgical follow-up; dental; orthopedic; infant hygiene; asthma; tuberculosis; neurological; and nose and throat.

Among the chronic sick, cardiac patients are evidently the group that most frequently receive complete service. Among any of the other groups receiving special attention from the social service, there may be chronic patients; and some of these groups represent chronic diseases; but the majority of the chronic sick are likely to be in the large group of patients who pass through the clinic unnoticed by the social service.

An administrative procedure, followed in some hospitals, that gives the social service department a natural contact with all patients is to have a medical social worker on the social service staff as the clinic executive. In the 55 hospitals studied, 21 had social workers as clinic executives in one or more clinics, but only three had this organization throughout the entire out-patient department. Unless the staff of social workers is adequate for all functions, there is danger in this system that the social service will not be able to perform its essential functions of social diagnosis and treatment.

b) Follow-up

By "follow-up" is meant the effort made by the clinic or hospital to keep patients in attendance at the clinic as long as the doctor considers it necessary. The term is loosely used in hospital statistics, as mentioned above, so that it is impossible to tell whether it involves a card asking the patient to return or an educational visit to enlist the interest of the patient or his family in cooperating with the clinic in his care. In the hospitals studied, this was sometimes a function of the social service and sometimes it was done as a clerical routine. Home visits were in some cases made by the social service when follow-up letters meet

with no response, or the service in some institutions was limited to letters. When the social service becomes acquainted with the patient and his social situation upon his first visit to the clinic or upon his admission into the hospital, this continued contact is more readily maintained and incomplete treatment is more likely to be avoided. This "follow through" system hasproved superior to the follow-after or follow-up system.(1)

Fifty of the 55 social service departments reported that they did follow-up work and five that they did not. Of the 55, only 6 departments follow up all of their patients. Forty-four departments did follow-up work only for referred patients or for certain diagnostic groups. Of these, 13 departments did follow-up for referred patients only; 9 for social service patients only. Others followed up one or more of the following groups: cardiacs, congenital luetics, diabetics, prenatal or post-partum patients, patients in the neurological, rheumatic fever, tuberculous, venereal, pneumonia, orthopedic, surgical, mental hygiene, infant hygiene, nose and throat, pediatric, or medical services; and patients discharged from the hospital and referred to the out-patient department.

In nearly all the hospitals follow-up is the responsibility of the social service; but in six hospitals the responsibility was given to clerical workers, rather than to social workers. In three of these hospitals, the clerical workers were responsible to the head of the social service and in three they were responsible to the hospital administration. Where

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(1) Davis, Michael, Clinics, Hospitals and Health Centers. Harper and Brothers, 1927, p. 485.

clerical follow-up is done under the direction of the hospital administration, patients are referred to the social service when follow-up letters produce no results. It may be a more economical division of labor to have clerks for the routine follow-up procedures and to leave social workers free for the functions of social diagnosis and treatment as a part of the whole process of rehabilitating the patient. This arrangement is considered to be best particularly when the follow-up is merely to determine end-results, as in post-operative cases. The simplest routine worked out for follow-up on all patients is the system whereby the doctor indicates on the medical record of the patient at each visit the date on which he should return. If the patient does not return, the doctor then indicates whether he should be followed up.

c) Relation of Medical and Social Records

Various methods are used to bring to the doctor the social information concerning his patient. It is agreed that to depend on conferences alone is not sufficient. Neither isolated items of social information included in the medical record nor periodic summaries of the social service record have been found altogether satisfactory. The filing of the social record with the medical record is still an experiment; but it seems reasonable to believe that, since social service is coming more and more to be regarded as an integral part of the complete care offered to patients by a clinic or hospital with its many special services, the social record will eventually be treated as an integral part of the medical record. At the Presbyterian Hospital, where the social service was carrying on studies for the purpose of developing higher standards of hospital social work, the

social record was filed with the medical record.

Information showing how the doctor obtains social information regarding the patient was secured for 53 departments. In 5 hospitals, the social information in full is filed with the medical record - Presbyterian Hospital, Beth David Hospital, Jewish Hospital of Brooklyn, Brooklyn Hospital, and Montefiore Hospital. The last two mentioned had just begun this system at the time of the survey. In all of the other 48 departments, interviews between doctor and social worker were chiefly relied upon for integrating medical and social care. The doctor might ask for such social information as he cared to have; or the social worker might bring to the doctor such information as she considered of value to him in making a diagnosis or a plan of medical treatment. In the larger clinics, it is practically impossible for the doctors to find the time to receive this information verbally from the social workers.

In 3 of these 48 hospitals in which the social information is filed separately, an exception is made for certain diagnostic groups and it is filed with the medical record. In one hospital this is done for cardiac, tuberculous, and syphilitic patients; in one for cardiac, mental hygiene, and infant hygiene patients; and in one for cardiac, syphilitic, and mental hygiene patients.

Four departments file a summary of the social information with the medical record for all patients under the care of social service. Six others file a summary with the medical record only in certain groups. In one, it is done for ward patients only; in another, for ward patients when the doctor requests it. In 2 departments, a summary is filed with the medical record for a patient in whose care the social worker thinks it would

be of value to the doctor. A fifth department files summaries with the medical records of all pediatric and cardiac patients, and a sixth, of all asthmatic, syphilitic, tuberculous, and cardiac patients.

All but 6 of the institutions in which the social service was studied had central medical records. Unless a unit system of filing has been installed, the social record may as well be filed separately. Three of the 6 institutions without a central medical record were planning a reorganization of their filing system.

d) Distribution of Social Workers

The 55 social service departments studied had staffs ranging from one to 32 social workers, with a total of 290 social workers. The average number for a department was about 5. Three-fourths of the departments had a staff of five or less. Table 7 groups the hospitals by the number of social workers in the department.

Table 7. Hospitals grouped by number of social workers in the social service department

Number of social workers in the departments	Number of hospitals	Total number of social workers
Total	55	290
One worker	15	15
Two workers	6	12
Three "	9	27
Four "	7	28
Five "	4	20
Six "	1	6
Eight "	2	16
Nine "	1	9
Ten "	3	30
Eleven "	1	11
Twelve "	1	12
Fourteen workers	1	14
Fifteen "	1	15
Sixteen "	1	16
Twenty-seven "	1	27
Thirty-two "	1	32

The predominance of the small department is indicated by the fact that, although the average number of social workers is over five, two-thirds of the hospitals had less than five.

IV

SUMMARY

1. Chronic illness is always a medical-social problem; and, therefore, it may be assumed that chronic patients as a rule require attention to their social needs and very frequently require social service as well as medical care.

2. Chronically ill patients require medical social service more frequently than the acutely ill.

3. It follows that the major part of the work of the social service department of a hospital has to do with the chronic sick.

4. In the prevention of chronic illness and incapacity, medical social service is as important as medical or nursing service.

5. Successful medical treatment in hospitals and clinics is not possible without social service in some chronic conditions. This has been demonstrated particularly in regard to heart disease and diabetes.

6. In certain cases of chronic disability after the condition has once been diagnosed, responsibility for the patient's care rests chiefly upon the social service.

7. Medical social workers in hospitals meet insurmountable difficulties in caring for chronic patients because of lack of facilities for their care in the community and lack of staff for adequate service.

8. The service given by medical social workers in hospitals may involve intensive medical-social treatment, assistance or advice in regard to a special problem, or cooperation with another social agency.

9. Research in medical institutions depends increasingly upon a well organized social service, as the emotional and social factors in illness are becoming better understood. The medical social worker contributes data in connection with the study of the disease and the plan for treatment, supervises the care and treatment of the patient at home, and follows-up the results of the treatment.

10. The role of the social worker in public health work is still undefined and should receive the joint consideration of physicians, public health nurses, and medical social workers.

11. Since medical social service is one of the most important and on the whole least recognized agencies for the prevention and care of chronic illness, in addition to the data obtained for this study, other available information has been assembled in order to throw as much light as possible upon standards and practices in this field in New York City. No general survey of medical social service departments has been made in this city, such as was recently made in Philadelphia.

12. The report on medical social work prepared for the White House Conference on Child Health and Protection, in 1931, is a comprehensive summary of the functions and practices of medical social workers; which should be a valuable guide in the organization of social service departments.

13. Of 117 public and private institutions for the sick in New York City that receive chronic patients of the types included in this study, 39 have no social service department.

14. Considerably more than a third of the chronically ill patients in hospitals with a social service department had received no attention from a social worker. Among those reported as known to the social service, the service given ranged from a single interview to intensive study and treatment.

15. Few of the social service departments of New York City have attained even approximately the minimum standards adopted by the American Association of Hospital Social Workers, in 1928, and embodied in the standards of the American College of Surgeons.

16. Professional education for medical social work is now offered in 10 educational institutions as a graduate course, usually recognized by the degree of A. M. or M. S. No standards of professional education for medical social workers are generally accepted in New York City; and in many hospitals little consideration is given to special training in the selection of personnel for social service.

17. The salaries paid to social workers in most hospitals are not high enough to attract professionally trained persons.

18. In this city, medical social service was initiated by nurses in contrast to other communities where it has grown out of social work. This led to the tradition that nursing education was essential for hospital social work, which still persists in the requirement that all social workers in municipal hospitals shall be nurses without the requirement of recognized social training.

19. The 55 social service departments surveyed, with staffs of from one to 32 persons, had a total number of 290 persons. Three-fourths of the departments had a staff of five or less. Only seven departments had ten or more.

20. The ratio between number of patients served and social service staff in different hospitals reflects the fact that the social service department is rarely planned in relation to the hospital's needs. The range is from one or two social workers for less than 2,000 annual admissions to one social worker for over 20,000 annual admissions.

21. The distribution of social service in the municipal hospitals is very uneven. A large part of the service is supported by voluntary auxiliaries, which are more active in some hospitals than in others.

22. In a majority of the hospitals, the organization of the social service is not in accordance with the accepted standard, that is, that the department should be an integral part of the institution and that its work should be integrated with the medical work and the other departments. In some instances, the department is administered almost entirely by an auxiliary group; and in other instances, so little allowance for its support is made in the hospital budget that its policies are controlled by the auxiliary group which provides the main support.

23. There is need for a clearer understanding of the functions of auxiliary committees and for the development of standard policies for their guidance.

24. The value of a good record system in improving the quality of the social service and increasing its contribution to the medical work has been demonstrated; but except in a few hospitals the records of New York City social service departments are far below the accepted standards.

25. In the recording of statistics, nearly every department follows its own method. The United States Children's Bureau is attempting

to collect statistics of hospital social service departments, along with other types of social agency, according to a carefully developed plan; but no department in this city has followed it so far.

26. In most of the social service departments, the facilities are inadequate for direct contributions to research. A few hospitals give evidence of a trend toward collaboration of the medical staff with the social service in medical-social research.

27. What proportion of the hospital budget should be expended for social service is a question that hospital boards and administrators are beginning to consider. It will of course vary in different types of hospital according to the nature of the patients served and of the services undertaken. Hospital administrators who recognize the values contributed to the hospital's work by the social service endeavor to secure for this service as adequate a staff as for the medical and nursing services.

APPENDIX I

List of 55 hospitals in which survey of the social service was made, classified by type of hospital

Total	55
Public	16
General	11
Bellevue Hospital	
City Hospital	
Coney Island Hospital	
Cumberland Street Hospital	
Fordham Hospital	
Gouverneur Hospital	
Greenpoint Hospital	
Harlem Hospital	
Kings County Hospital	
Lincoln Hospital	
Metropolitan Hospital	
Special	5
Kingston Avenue Hospital	
New York City Cancer Institute	
Riverside Hospital	
Sea View Hospital	
Willard Parker Hospital	
Private	39
Chronic	2
Montefiore Hospital	
New York Skin and Cancer Hospital	
Orthopedic	3
Hospital for Joint Diseases	
Hospital for Ruptured and Crippled	
House of St. Giles	
General and other special	34
Babies Hospital	
Beth David Hospital	
Beth Israel Hospital	
Beth Moses Hospital	
Bronx Hospital	
Brooklyn Hospital	
Fifth Avenue Hospital	
Jewish Hospital of Brooklyn	
Knickerbocker Hospital	
Lebanon Hospital	

List of 55 hospitals in which survey of the social service was made, classified by type of hospital (continued)

Lenox Hill Hospital
Long Island College Hospital
Lutheran Hospital
Methodist Episcopal Hospital
Mt. Sinai Hospital
Neurological Institute
New York Hospital
New York Infirmary for Women and Children
New York Nursery and Child's Hospital
New York Polyclinic Hospital
New York Post Graduate Hospital
Presbyterian Hospital
Reconstruction Hospital
Rockefeller Institute
Roosevelt Hospital
St. John's Hospital of Brooklyn
St. John's Long Island City Hospital
St. Luke's Hospital
St. Mark's Hospital
St. Mary's Hospital
St. Vincent's Hospital
Staten Island Hospital
United Israel-Zion Hospital
Woman's Hospital

APPENDIX II

A Standard Training Course for Medical Social Workers[1]

"The course as planned by this Committee offers two academic years. Approximately half of this time is given to practice, approximately one-quarter to classroom work, and approximately one-quarter to reading and other preparation.

"In general, the plan advocated by the Committee for the curriculum is as follows:

"A. Primary -- To establish technique of work.
Social case work.
Problems of medical social work.
Psychiatric and psychological principles of human behavior.
Statistics.

"B. Secondary -- To establish background.
Medical.
Physiology and hygiene.
Certain physical diseases.
History and organization of medical practice.
Public health.
Social.
Government.
Community organization.
Industrial organization.

"The subjects listed under "B" are necessary to give the student medical and sociological background and an orientation in his field.

"An understanding of the normal functioning of the body, the chief causes of its disturbance, and the means of maintaining health is

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(1) Report of the Committee on Training for Hospital Social Work. The American Hospital Association, Bulletin No. 55, 1923, pp. 20-22.

a necessary part of the equipment of any social worker. A course in physiology and hygiene should be taught as much as possible by means of practical demonstration. It should cover the principles of growth, development, nutrition, and infection.

"The hospital social worker needs to know the social significance of the common diseases, especially the chronic infections and those diseases which cause permanent or long-continued social disability. She needs to know their social causes and results, the conditions necessary to recovery, and the means of protecting others from infection and undue burden of care. Courses in disease should, like courses in hygiene, be taught by clinical demonstration and by classroom discussions, as well as by lecture.

"A course in the history and organization of medicine and nursing and of medical institutions is advised for the purpose of giving the hospital social worker an intelligent understanding of the habits, ethics, and instruments of the professions with which he must be associated in his work. The hospital social worker has to interpret physicians to members of the community, and has, moreover, often to guide individuals in the securing of proper medical care. He should, therefore, have some basis for judging the reliability of medical practice, as well as for intelligent cooperation in a medical plan."